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St. Bartholomew's Hospital Journal,

DECEMBER 14th, 1898.

"Æquam memento rebus in arduis
Servare mentem."—*Horace,* Book ii, Ode iii.

BEFORE we go to press again an event full of interest for all concerned in the life of a large hospital will have come and gone. The provisions made for the patients' comfort and enjoyment at Christmas-time are very varied. Sundry indulgences inseparable from the idea of an English Christmas are allowed to creep into the usually sober diet sheets, and tax the wisdom of the house physician and sister not a little in the selection of fit cases for their consumption. A thoughtful laxity has even permitted the solace of a pipe in the Square to such as deem enjoyment of *any* sort impossible without it. There are evergreens and berries and decorations and Christmas-trees and bran-pies filled with toys galore. All this is lawful and right—indeed, is in great measure kindly superintended by the steward on the Hospital's behalf.

The other element that completes the cup of the patients' happiness, however, is that constituted by the many forms of entertainment in the wards. Upon the manner of these the authorities exercise a jealous outlook, to the extent, in fact, of yearly proclaiming an official veto upon anything of the kind. Pianos and such like "big pieces of music" are rigidly forbidden. But hitherto the resources of the Junior Staff have not been limited, nor has their ardour been easily damped. Violins and other stringed instruments, and a certain hybrid piano-harmonium that, when judiciously stuffed with cotton wool, can be made to do the work of a piano fairly well, are called into requisition as accompaniments to the human voice. Pierrot troupes, and "bigaphone" bands, and human menageries, and magic lanterns, and conjuring performances swell the list of past years.

We are emboldened to plead for some leniency on the part of the House Committee in this respect. We have seen the genuine pleasure the performances yield; we also know by experience the trouble and care expended by the Resident Staff in the selection of suitable forms of entertainment. That the sick folk are disturbed by these things we regard as a fiction. Our double wards are admirably fitted for preventing this; for the tactful sister, having fully endorsed the steward's annual warning against permitting entertainments, straightway proceeds to arrange the beds so that any patients who are acutely ill may be where few, if any, sounds can reach them. We often heard laments from those whose condition seemed to need this safeguard; we never heard complaints from those who were allowed to join in the festivities. Moreover there are more convalescent patients in the Hospital at Christmas than at any other time of year. The request to "stay in over Christmas" seldom goes unheeded, especially in the case of children, and those whose home is anywhere they happen to be at the time their "home" is asked about. (The suggestion we have sometimes heard, that children are admitted especially *for* Christmas,—that there are such things as "nice Christmas boys," for instance, is, of course, a myth.) A sister's knowledge of her patient's home

circumstances is often a wonderful thing,—as thorough as the physician's knowledge of his bodily distress.

The result of all this care and discrimination is a great feast of happiness for the men and women, and the keen delight of the children,—who, that is a child no longer, can gauge it? Desirable as it is to stop short of the possibility of measuring a patient's enjoyment by the amount of febrile reaction, it will be allowed that the traditional toast we so often drink, "Health and Ease to Poor Patients," may quite reasonably include the desire that a glad and festive time will mark Christmas, 1898, for the Hospital inmates. We expect it will, for things will probably be as they have been. On the one hand, the Junior Staff will vie with each other in their preparations, the Nursing Staff will lend their welcome assistance, and the patients will put red letters against the days. On the other hand, when all is over, the Committee will sit in censure upon such unwise methods of amusement as must have been adopted if the *Evening Satellite* speak truth, various people will be cross-questioned, the bills of mortality for the week will be tremblingly consulted, and found with a sigh of relief to be much the same as for any other week, and the grave seniors will disperse with a sense of duty done, to forget it all until after Christmas, 1899. Let not the cynic laugh; it is but a case of the struggle evolving a custom that survives because it is fittest. No Christmas festivities would make the season a dismal time; but festivities that are not kept within appropriate limits are none the less to be deplored.

Primary Tuberculosis of the Nasal Cavities,

Being the Abstract of a Clinical Lecture delivered at St. Bartholomew's Hospital,

By W. J. WALSHAM, F.R.C.S., Surgeon and Lecturer on Surgery to the Hospital.

PRIMARY tuberculous disease of the nasal cavities would appear to be rare. Little or nothing is said about it even in the larger works on surgery. Indeed, by some rhinologists of repute its existence has been denied. That it does occur, however, has been conclusively shown by the cases published by Herzog, Demme, Schaeffer, Ruault, and Michelsohn; and that it is not so rare as has been assumed is further demonstrated by the fact that during the last few years I have seen at least five cases in which I think there could be no doubt of the tuberculous condition being primary. As a secondary affection to lupus of the ala nasi, upper lip, or cheek, it is probably familiar to most surgeons, though secondary invasion of the nasal cavities in this way is by no means, as far as my experience goes, common. The same may be said of it as a secondary affection to tuberculosis of the palate, pharynx, larynx, or lungs. It would appear, therefore, that the nasal mucous membrane has a decided immunity to the tubercle bacillus. Indeed, one of its functions would seem to be the removal or destruction of deleterious particles (amongst which may be placed the tubercle bacillus), and the consequent prevention of their gaining access to the upper respiratory passages.

When the interior of the nose is attacked it is nearly always the anterior part, and perhaps most usually the anterior part of the septum. The reason for this may be that the mucous membrane in this situation is more liable to abrasion or injury, and thus to inoculation with the bacillus. In a case reported by Jurasz * the infection was clearly carried by the left thumb, the skin of which was the seat of tuberculous ulceration. A further explanation of the occurrence of the disease at the anterior part of the septum may possibly be found in the fact that at this spot is situated the rudiment of the organ of Jacobson. Here the tissues, as is the case with other rudimentary structures, may, I think, be reasonably assumed to be less stable than elsewhere, and hence may more readily succumb to the attacks of the bacillus. Moreover to a low resisting power of the tissues in this situation has been attributed the slow destruction of the tissues and perforation of the septum (simple perforating ulcer) that not infrequently occurs here.

Although tubercular disease has a predilection for the anterior end of the septum, and perhaps less frequently for the anterior end of the inferior turbinal body, other parts may be attacked, as the middle turbinal body, the floor of the nose, and in rare instances the osseous septum.

Primary tuberculosis of the nose may assume one of two forms. Either (1) an outgrowth or heaping up of granulation tissue, the *hyperplastic variety;* or (2) a condition in which ulceration occurs, so to speak, commensurately with it or so closely follows, that very little increase in tissue formation is noticeable, and almost from the first the disease assumes the form of an *ulceration.* In these respects its behaviour is similar to what we are all familiar with in the case of epithelioma, which may appear either as a cauliflower-like mass, or as an ulcer almost from the commencement of the disease. As in epithelioma, moreover, the increased tissue formation and ulcerative process is frequently combined. In the cases which have come under my personal observation, in six the disease was of the hyperplastic variety, the patient suffering from nasal obstruction. In two there was little if any new growth, but the characteristic ulceration was present. Two of my patients were women, the others were men or boys.

Symptoms.—At first there may be no symptoms. Later, stuffiness in one or both nostrils or more or less complete obstruction, according to the size of the growth, was the chief symptoms in my cases of the hyperplastic form. As in some of the cases reported there has been an occasional

* 'Die Krankheiten der obern Luftwege,' Heidelberg, 1891, p. 2.

escape of a drop or two of blood; in a few a severe epistaxis. In the ulcerative variety a watery muco-purulent or slightly blood-stained discharge, with at times a fœtid odour, has been observed combined with more or less obstruction when the disease has taken the mixed form. On inspecting the nasal chambers after the adherent greenish-yellow crusts have been removed in the *hyperplastic* variety, an irregular reddish-grey, soft, friable, vascular, and granulation-like swelling is discovered. It bleeds when touched with a probe, but not as a rule profusely; at least such is my experience, but free bleeding is said to have occurred. The mucous membrane around is not thickened, but may be studded with one or more similar tumours of a smaller size, or may present in the neighbourhood of the growth a shallow ulcer. In my own cases the growth had obtained a large size, and completely blocked both nasal passages. The septum presented a large perforation, but there was no dead bone discoverable, and the hard palate was not affected. In one of the cases the growth had invaded the right lateral cartilage, and had led to some localised bulging of the nose on that side. In none of my other cases was there any external deformity except in one in which the nose had become saddle-shaped, but there was some doubt in this instance if the disease was primarily nasal.

In my own cases of the *ulcerative* form, there was over the anterior end of the left inferior turbinal body a greyish irregular ulcer which had more or less destroyed the anterior third of the turbinal body, and involved the contiguous mucous membrane covering the outer wall of the nose. The edges of the ulcer were slightly if at all raised, and somewhat irregular in outline, and the surrounding mucous membrane was healthy. In one case, on probing the base of the ulcer, which was covered with an ashy grey slough, some exposed bone was discovered.

Diagnosis.—1. The *hyperplastic* form may readily be mistaken for sarcoma. Indeed, one of my cases was sent to me under the supposition that it was a recurrent sarcoma. A growth had been removed by the intra-nasal method, and the patient informed by a provincial rhinologist that she had only six months to live. This form might also possibly be mistaken for a gumma, or for an impacted foreign body surrounded by granulation tissue, or even for a papilloma the softer varieties of which may bear some resemblance to a tuberculous granuloma.

In the early stages of a malignant growth the symptoms and signs may be so similar that it may be impossible to make a diagnosis with any degree of certainty without watching the patient for some time. The removal of a portion of the growth and submitting it to microscopical and bacteriological investigation may be of material assistance, but cannot be absolutely relied on, as the microscopical examination may reveal little more than the presence of granulation-like tissue; and the bacillus, even though the growth is tubercular, may not be discovered. Some forms of malignant growth in the nose are exceedingly slow in their progress. Too much reliance, therefore, cannot be placed on the rate of growth. In the later stages, that is when ulceration of a malignant growth has occurred, the more vascular appearance of a sarcoma, its purplish-red colour, its greater tendency to bleed, and the history of violent attacks of epistaxis, will point to its malignant nature. But even then a microscopical examination and a search for the tubercle bacillus should not be omitted for the purpose of confirming the diagnosis.

In carcinoma, disintegration of the tissues takes place with great rapidity, and soon involves the deeper structures. The margins of the ulcer, in place of being soft, are hard, sinuous, raised, and irregular.

From a gumma before it is broken down there should not be much difficulty in distinguishing a tuberculous granuloma, since in the early stages the surface of a gumma is smooth and unbroken; whereas in the tuberculous granuloma, except perhaps in the very early stage, the tumour is granular and friable. The administration, moreover, of a few doses of iodide of potassium will, as a rule, rapidly clear up a gummatous swelling.

From such affections as nævus, angiomata, and soft papillomata there should be little or no difficulty in distinguishing a tuberculous affection if ordinary care be taken.

The hyperplastic form of tuberculous disease, when attacking the inferior or middle turbinal bodies, may not only be mistaken for a malignant growth or gumma, but for hypertrophic rhinitis. As a rule, however, the smooth surface of the enlarged turbinals would be sufficient to prevent such a mistake. But in the so-called papillary form of hypertrophy an error might possibly occur.

2. The *ulcerative* form is most likely to be mistaken for syphilitic ulceration, possibly for breaking-down carcinoma.

In syphilitic ulceration the tissue destruction is generally more extensive and deeper, and on probing, necrosed bone will, as a rule, be felt. The ulcer is deeply excavated. Its edges are irregular, overlaying, and ragged, surrounded by a bright shining areola. Whereas in tuberculous ulceration the destruction of the tissues is less extensive and not so deep, and no necrosed bone is as a rule felt. The ulcer is generally irregular or oval in shape; its sides are level with the surrounding mucous membrane, or very slightly raised; its floor is whitish or yellowish grey, or it may be covered with caseating nodules or crusts. The surrounding membrane is probably healthy, and there is no bright shining areola.

It has been affirmed that in syphilis, should perforation occur, it is more often the osseous part of the septum that is involved. It is a question, however, if such is really the case. A point of distinction which has been made much of, therefore, that tubercle involves the cartilaginous, syphilis the osseous part of the septum, must not be too much

relied upon. A fact to which I myself attach more importance is the frequency with which perforation of the hard palate occurs in conjunction with syphilitic perforation of the septum. I have met with it so frequently during the seventeen years I had charge of out-patients, that I feel sure that it is a very common accompaniment of syphilitic perforation, and I know of no case in which primary tuberculous perforation of the septum has led to a perforation of the hard palate.

So far I have only called attention to the diagnostic appearances of the two conditions. Frequently there are concomitant signs of syphilis, such as gummatous swellings over the nasal bones, the cranial bones, or elsewhere, or scarring of the palate or pharynx, or other evidences of syphilis present or past which will confirm the local appearances.

In malignant ulceration the extension is rapid; the edges are sinuous in outline, everted and indurated, and its base covered by a sanious discharge, through which irregular fungating masses of granulations may be seen projecting. Profuse attacks of epistaxis have probably occurred.

Glandular enlargement in the neck may occur in both malignant and in tuberculous ulceration; in the former, of course, as secondary to the primary nasal trouble; in the latter either as a part of the tuberculous dyscrasia, or perhaps as secondary to the nasal tubercle. There was not, however, any glandular enlargement in any of the cases of nasal tubercle that have come under my own observation.

Prognosis.—The prognosis as far as life is concerned appears to be good, since cases have been reported in which the disease has existed many years without dissemination having occurred, or neighbouring parts having become involved. On the other hand, however, the primary trouble has rapidly terminated in tuberculous meningitis or in tuberculosis of the larynx or lungs, and external disturbance of the palate and neighbouring parts has been known to occur. The risk of the tubercle spreading along the lachrymal canal to the lachrymal sac, and thence to the conjunctiva, must not be lost sight of. I have seen this condition threatened as evidenced by some obstruction of the duct, but the further spread of the mischief was prevented by the thorough scraping at the entrance of the duct in the inferior meatus.

As regards a complete cure the prognosis is much less favourable, as relapses after the apparent complete extinction of the disease are very common. In most of my own cases there has been one or more relapses, except in the case in which the tuberculous granuloma of the septum was widely removed with the knife. In this case so far there has been no return of the disease.

Treatment.—In the early stages of the disease and in slight cases an attempt may fairly be made to cure the disease by thorough scraping with Grunwald's curettes, and the subsequent application of the galvano cautery or lactic acid; but to ensure, as far as this can be done, complete eradication of the disease the more radical operation should be undertaken,—that is, the nasal cavity should be laid freely open, and the disease as far as possible completely cut away with the knife. In a case under my care some twelve months ago in the hospital I split the nose in the middle line, turned the nasal bones outwards, and in this way obtained a thorough exposure of the neoplasm, which was confined to the anterior two thirds of the septum. The growth was then extirpated, together with a wide margin of healthy septum. Care was of course taken not to injure the upper margin of the cartilaginous septum, since as long as this remains intact there is little or no risk, as far as I know, of the nose falling in. After the removal of the growth the nasal bones were carefully replaced, and the skin wound *equally* and accurately united with horsehair sutures: the resulting scar was hardly perceptible. I have no doubt in my mind that, except in slight and early cases, some such exposure and thorough removal holds out the best prospect of success, both as regards a local relapse and prevention of tuberculous dissemination. Unfortunately, however, it is difficult to convince patients in the earlier stages of the disease of the necessity of what appears to them a formidable procedure. They are apt to elect the less radical intranasal method. In two other of my cases I am sure that the radical removal of the disease was very strongly indicated, but both patients absolutely refused to give me a free hand. One is still under treatment, and is apparently nearly cured; the other has had several relapses after intranasal scraping. I have not seen her since the last operation. From the condition of her nose when last seen I should think another relapse is likely to occur.

The Surgical Treatment of Chronic Otorrhœa.

A Paper read before the Abernethian Society, November 10th, 1898,

By EDMUND W. ROUGHTON, B.S.Lond., F.R.C.S., Surgeon to the Royal Free Hospital, and Surgeon in charge of the Throat and Ear Department.

PROBABLY there are but few serious diseases which are more common, and at the same time more often neglected, than chronic otorrhœa. Many patients of the poorer class do not seek treatment unless the otorrhœa is attended by deafness or other symptoms which interfere with their occupation; and many parents, whose children have discharge from the ears, regard the condition as a natural one, or as one not worth the time and trouble to get it cured.

Nevertheless there are a large number of cases of otorrhœa who seek relief at our hospitals, and I think it must be admitted that some of them do not obtain the full benefit which surgery is able to

confer on them. This is, no doubt, chiefly because they do not carry out the treatment prescribed, but to some extent it is because the nature of the morbid condition and the principles of treatment are not always sufficiently appreciated.

Twenty years ago the majority of practitioners were content to accept the ancient dictum that there were two classes of diseases of the ear, those that could be cured by syringing, and those that could not be cured at all. The latter class included most cases of chronic otorrhœa. During recent years the progress of surgery has taken chronic otorrhœa out of the list of incurable affections and placed it amongst the list of diseases amenable to operative measures conducted on well-recognised surgical principles.

It is well to remember that most cases of otorrhœa begin as an attack of acute otitis media, and that the discharge persists and becomes chronic because the primary disease is inadequately treated, or not treated at all. It is not within the scope of the present paper to discuss the treatment of acute otitis media, but there is one point to which I wish to refer briefly. It is the question of opening the mastoid antrum in acute or subacute cases. Most surgeons are agreed that when there are undoubted signs of suppuration within the mastoid, early opening and drainage are advisable. There are cases, however, in which the mastoid antrum and cells are involved in the suppurative process and yet there is no mastoid pain or tenderness, because there is no actual retention of pus under pressure or tension. These cases require careful consideration because they are difficult to diagnose, and they are very prone to lapse into chronicity. If we find that pus reappears very quickly after cleansing and drying the middle ear by syringing through the meatus and inflating through the Eustachian tube, we may infer that it is not simply secreted by the tympanic mucosa, but that it comes from the mastoid antrum and cells. This suspicion is strengthened if we find a slight bulging or dip of the postero-superior wall of the meatus near the membrane, and an increase of temperature of the posterior wall of the meatus over that of the anterior.

Under such circumstances the mastoid process should be explored. The result may of course be negative, in which case we can close our incision and no harm will be done. If, however, we find pus, its evacuation and drainage will greatly expedite the termination of the case.

Space will not permit me to enter further into what may be called the preventive treatment of chronic otorrhœa, but I will briefly refer to the conditions which lead to a continuance of the discharge, for unless these conditions are understood our treatment will be neither scientific nor successful.

As I have already said, some cases of simple acute tympanic inflammation become chronic because they are untreated. In such cases we may hope for a cure by the use of the ordinary antiseptic remedies applied through the external meatus.

In others we find that the condition is maintained by some constitutional dyscrasia, such as syphilis, tuberculosis, anæmia, &c., or by some disease of the nose or naso-pharynx. Such cases will recover under the influence of tonics and other internal remedies, and removal of adenoid vegetations and other morbid conditions of the upper air passages.

Not unfrequently the persistence of the disease leads to, and is itself maintained by, the presence of granulations, polypi, caries of the ossicles, or of the bony walls of the tympanum. These conditions can often be remedied by appropriate treatment conducted through the external meatus. These I shall not enter into, as they would lead me too far afield.

In a large number of cases the inflammatory process has involved the tympanic attic, the mastoid antrum and cells, filling these cavities with septic masses of pus, granulation tissue, and cholesteatoma, and leading to caries and absorption of the osseous tissue. Here the morbid condition is out of reach of any treatment conducted through the meatus, and can only be attacked by the operation of mastoidectomy.

Since 1892 I have performed this operation just on fifty times for patients suffering from an otherwise incurable otorrhœa. The following remarks are based chiefly on a study of the notes of these cases.

Let us consider in the first place the indications for mastoidectomy; in other words, when should we advise this operation?

Briefly it may be stated that if we fail to cure a case of chronic otorrhœa after three months' treatment through the external meatus, we should advise operation. Further it may be added that in cases where there are definite indications of involvement of the mastoid antrum ordinary aural treatment will be a waste of time, and the sooner mastoidectomy is performed the better.

In the next place, what do we hope to obtain by operation? We seek to cure the discharge and to free the patient from the danger of intra-cranial diseases which a sufferer from otorrhœa may at any moment fall a victim to. It must be clearly understood that the co-existent deafness will not be relieved, but at the same time one can promise that any hearing power the affected ear may have will not be destroyed.

Before describing the operation of mastoidectomy it may be well to recall to mind some points in the anatomy of the parts concerned. The mastoid antrum is a roughly spherical cavity about a quarter of an inch in diameter, which communicates with the upper and posterior part of the tympanic cavity by means of a passage known as the "iter." The mastoid antrum is present at birth, and must be carefully distinguished from the mastoid cells which open into it, and which are developed later in life. It is not situated in the mastoid process, but in the base of the petrous portion. Its depth from the surface varies from three fifths to three quarters of an inch. The roof of the antrum (tegmen antri) is continuous with the roof of the tympanum (tegmen tympani), and is formed by that portion of the base of the middle fossa of the skull which lies immediately outside the prominence of the superior semicircular canal.

The "iter" or passage of communication between the antrum and the tympanum lodges the short process of the incus. The inner wall of this passage is separated from the external horizontal semicircular canal by a thin plate of very dense bone. The canal for the facial nerve runs downwards and backwards in very close relation with the inner wall and floor of the iter near its opening into the tympanum. The mastoid antrum is most accessible from the surface through a small area known as the supra-meatal triangle.

This triangle is bounded above by the posterior root of the zygoma, below and in front by the postero-superior quadrant of the orifice of the external auditory meatus, and behind by an imaginary vertical line passing through the posterior margin of the meatus.

The bone intervening between the supra-meatal triangle and the antrum varies in character; sometimes it is diploic, like the bone between the compact plates of the vault of the skull; sometimes pneumatic, *i. e.* hollowed out by air-cells; and sometimes it is sclerotic, or composed of dense ivory-like bone. The last condition is often found in cases of chronic otorrhœa.

Preparation of the Patient.—On the night before the operation half the head should be shaved and the skin scrubbed with soap and water, followed by the use of turpentine or ether to remove the fat. The external ear and meatus is cleansed with 1 in 1000 biniodide solution, and the scalp mopped over with a 1 in 500 solution of biniodide in 75 per cent. spirit. A compress of 1 in 2000 biniodide is then applied to the part, and left there until the patient is anæsthetised.

The anæsthetic I prefer is the A.C.E. mixture.

Operation.—The auricle is drawn forward, and a curved incision is made from the apex of the mastoid process passing upwards an eighth of an inch behind the attachmeut of the auricle to a point vertically above the meatus. All the soft parts, including the periosteum, are severed. With a periosteal elevator the auricle and the tissues in front of the incision are separated from the bone and pushed forward. The skin lining the meatus is detached on all sides as far down the bony canal as possible, and displaced forwards with the auricle. Several vessels require ligature at this stage. A strip of sterilised calico bandage is then passed through the meatus and out of the wound, its two ends tied together and used as a retractor to draw the external ear and cutaneous meatus well forward.

The osseous meatus and the bone behind and above it are then exposed to view as freely as in the dried skull, and the position of the supra-meatal triangle is easily defined.

The next stage of the operation consists in opening the antrum by perforating the bone through the supra-meatal triangle. There is much difference of opinion amongst surgeons as to what is the most suitable instrument to use for this purpose. Some use a trephine, others a gouge, and others a hammer and chisel. I have discarded these instruments in favour of drills and burrs similar to those used by dentists, and have been well satisfied with them. Others have used dentists' drills and have found them unsatisfactory. I think the reason of this is that the drills and burrs they use are too large for the motive power with which they propel them. I find that the ordinary dental engine worked with the foot is not sufficiently powerful, but that the small electro-motor supplied for the purpose by Mr. Schall, the electrician, gives plenty of power. The handpiece which carries the drills is connected to the electro-motor by an ordinary flexible cable, which, however, must differ from that generally used by dentists in two respects. Firstly, there must be an insulation, so that the current cannot pass to earth from the motor through the patient or operator; and secondly, there

must be an arrangement so that in the event of the drill suddenly becoming arrested by a hard piece of bone the motor can overrun without breaking the cable.

The drilling is commenced with a fissure burr one sixteenth inch in diameter. This penetrates the compact tissue quickly and easily. When the hole has reached the depth of three sixteenths of an inch it is enlarged laterally by a circular swaying motion of the hand, whilst the point of the instrument remains steady. The fissure burr is then changed for a rose-headed burr, which is used to enlarge the opening to five sixteenths of an inch in diameter.

In this manner the opening is gradually deepened until the mastoid antrum is reached, but at the same time that the hole is deepened the adjacent portion of the posterior bony wall of the meatus is removed, so that the cylindrical hole becomes a deep groove. The antrum is easily recognised when reached by means of a bent probe passed through the iter into the tympanum. The height of the antrum varies somewhat, especially in reference to the level of the floor of the middle fossa. Several times I have found the floor of the middle fossa below the level of the posterior root of the zygoma, and have consequently penetrated into it, but I have never penetrated the dura mater.

Another important anatomical relation to be considered in this stage of the operation is the lateral sinus. Lake, from a series of investigations, has found that the lateral sinus groove reaches forwards to a variable extent, so that in some cases it comes within the line of fire from the supra-meatal triangle to the antrum; in others it comes near the line, whilst in a third class it is well behind it and out of harm's way. I have several times exposed the sinus, but have never penetrated into it.

The next stage of the operation consists in removal of the outer wall of the iter or passage leading from the antrum to the tympanum. In doing this one must remember that the external semicircular canal and the canal for the facial nerve are in very close relation with the inner wall of the iter. These structures must be protected by inserting the bent end of a probe into the passage whilst the outer wall is burred away. The long process of the incus is now usually encountered lying in the iter. With a bent probe or hook the ossicle is removed. The malleus is then sought for in the upper part of the tympanum, and removed in a similar manner. To complete the exposure of the upper part of the tympanum or attic it is usually necessary to remove a portion of the outer wall of the latter. This is done by inserting a small rose-headed burr into the cavity of the attic, and making it cut its way outwards.

The antrum, iter, and tympanum are now thoroughly scraped, all granulation tissue, inspissated pus, &c., being removed. The hæmorrhage is from time to time arrested by strips of antiseptic gauze; when the latter is withdrawn the walls of the cavity, especially the antrum, are carefully examined with a fine probe to discover any cells or recesses leading off from them. If such are found they are laid open, and their walls smoothed down with the burr, so that the external meatus, tympanum, attic, antrum, and mastoid cells are made into one large smooth-walled cavity. Some boracic lotion is then injected through a Eustachian catheter, so as to wash out any septic matter lurking in the Eustachian tube.

When I am not satisfied that I have been able to remove all septic granulations or carious bone as thoroughly as I could wish, I complete the disinfection with pure carbolic acid applied on a small piece of wool held with forceps. I then slit the back of the cutaneous meatus longitudinally in its whole length, and stitch it into the wound so as to apply it as closely as its size will permit to the posterior part of the newly made bony cavity. The latter is then packed with iodoform and glycerine gauze introduced through the meatus, and the mastoid incision is sewn up. Finally, an ordinary antiseptic dressing is applied.

After-treatment.—I usually perform the first dressing after forty-eight hours. It is not safe to leave it for a week, as one does in an ordinary aseptic operation, on account of the difficulty and uncertainty of rendering such a complicated bony cavity thoroughly aseptic.

If the case is progressively satisfactory, and there is no pain or rise of temperature, the second dressing may be left for two or three days. The stitches are removed from the mastoid incision after eight days, and the meatus is plugged with gauze daily until there is no further exudation. It is extremely important that the plugging should be introduced right into the tympanum and antrum, and not simply laid in the meatus. In some of my cases in which the dresser has failed to introduce the gauze plug beyond the limits of the cutaneous meatus the latter has contracted at its internal extremity to a minute aperture, and has led to retention of discharge and decomposition.

One great difficulty in the subsequent treatment of these cases is that they require careful supervision for about three months after the operation, and it is impossible to keep them in hospital for that length of time, and when once they have returned to their usual unsanitary surroundings there is considerable risk of the bony cavity becoming septic before it is quite healed. When the patient is unable to attend daily for treatment I give him a solution of boracic alcohol, grs. xl ad ℥j, to drop into the ear night and morning.

Results.—We must consider the results of this operation under the following heads:

Cure of discharge.
Hearing power.
Immunity from cerebral complications.
Injury to facial nerve and consequent paralysis.
Mortality.

Cure of Discharge.—From the patient's point of view this is the object most aimed at. It must be admitted that we do not always completely succeed in attaining this end. In the majority of my cases when discharged from the hospital there has still been a very slight exudation, just sufficient to prevent one from saying that it is entirely cured. When these cases leave the hospital one very often loses sight of them, more especially if they are free from trouble. They do not as a rule come to see one with the simple object of reporting that they are well. Nevertheless I have seen a sufficient number of these cases at a subsequent period, when they have turned up on account of some other ailment, to be able to say that in a good number the discharge ceases entirely. More precisely I cannot speak.

In a certain number a very small amount of mucous or muco-purulent discharge persists, but it is in such small quantity that it is scarcely a source of annoyance to the patient. It must be remembered that the tympanic cavity is no longer covered with a protecting membrana tympani, and that any mucous membrane which remains, being subject to the irritation of air, dust, &c., is very likely to pour out a certain amount of secretion.

Hearing Power.—It must be understood that this operation is not undertaken with the object of improving the hearing. As a general rule these patients are very deaf in the affected ear before the operation, and remain in the same condition afterwards. As a rule a watch is only heard on contact. In none of my cases has the hearing been made any worse, but this is not saying much. In a few cases, however, the hearing has been distinctly improved, a watch being audible as far as three inches, and loud conversation being easily understood.

Immunity from Cerebral Complications.—It is here, I take it, that the patient gains most, although this is the result that he appreciates least, and at the same time it is a result which is most difficult to prove one has obtained. In none of my cases has any cerebral complication supervened, yet it must be at once admitted that their number is so small that the statement is of no value. It is quite possible, even probable, that none of them would have succumbed to cerebral disease if they had not been operated on.

It cannot, however, be denied that a patient whose tympanum and accessory cavities have been converted into one large scar-lined space is in far less danger of cerebral trouble than one whose attic, antrum, and mastoid cells are full of pus and pyogenic bacteria, which may at any moment be shut off from the external meatus, and seek an exit into the cranial cavity.

Injury to facial nerve, &c.—In two of my cases the antrum and mastoid cells had been eroded and expanded to such an extent that a portion of the outer wall of the aq. Fallopii was destroyed, and the nerve laid bare to the extent of about a quarter of an inch. In these the face twitched several times while the cavity in the bone was being cleaned out, and slight facial paralysis ensued; but it was only of temporary duration, and completely disappeared in a few weeks.

In one case, however, on which my house surgeon operated under my supervision, complete facial paralysis on the affected side was noticed as soon as the patient recovered from the anæsthetic. In this case partial recovery ensued, but when the patient left the hospital she was still unable to close the eye completely, and I expect she will always have a certain amount of facial paralysis. Nevertheless she was pleased with the result of the operation, as her discharge was cured and her hearing distinctly improved.

Mortality.—As far as I know all my cases are still alive. It may, therefore, be safely concluded that none of them died directly or indirectly from the operation.

My series of cases is not sufficiently large to enable me to say what is the mortality of the operation, but it may safely be concluded the danger of the operation itself is very small.

A study of these cases leads me to the following conclusions:

(*a*) The operation is justifiable and advisable in all cases of

chronic otorrhœa which have resisted treatment through the external meatus for three months.

(*b*) It is practically devoid of danger to life.

(*c*) The facial nerve is subjected to risk of damage, and particular care to avoid it must be exercised.

(*d*) The hearing power is never diminished, sometimes improved, but usually unaltered.

(*e*) The discharge is always diminished, frequently cured.

(*f*) The risk of subsequent intra-cranial disease is reduced to a minimum.

Some Experiences of Plague Duty in India.

By W. NETTERVILLE BARRON.

(*Concluded from p 29.*)

EVICTION, with consequent segregation and quarantine, led, however, to our most serious differences of opinion. One night at Munmar, when I was comfortably asleep, I was aroused by a total stranger, who was armed to the teeth and accompanied by an escort of two sepoys similarly equipped. He informed me that perhaps I had better get up, as serious rioting was going on in an adjacent village, which had already resulted in the death of one doctor and a perfectly inoffensive pleader. I rose with the feeling that the hospital square presented undoubted advantages in the way of a peaceful life, for there, except for keeping a wary eye on the surgical registrar, or avoiding a demonstrator of anatomy, troubles might be classed as minor. Having seen my belligerent friend off to the scene of the fray, I settled down to an anxious night, as I was not at all sure my own particular camp would not be fired with a patriotic enthusiasm to shake off the yoke of the foreigner. Dr. G—, I.M.S. at Sinnar, had to fly for his life. Luckily he had a fleet horse, but as it was he lost all his kit, which was either burned or stolen. Again, at Malegaon we had a "how-d'ye-do" which might have been very serious, but which, fortunately for us, only resulted in our being pelted with carrots and otherwise freely insulted. It was at Malegaon, too, that I was informed one evening that all the doctors and all the nurses in Bombay had been murdered, and that my best plan would be to beat a dignified retreat; in fact, to go without being pushed. Not seeing any advantage in this plan, and disbelieving the report, I remained where I was, and nothing happened. I was, I regret to say, out of the Bombay row, but Winter was well in it, and so was Guyon Richards, who, if report speaks truly, performed prodigies of valour, and left his mark on more than one Mussulmany pate.

Low caste Hindoos are generally dirty, low class Mussulmans are always so. This may be taken as a rough rule to go by, of course remembering that my experience is strictly confined to the Bombay Presidency. It is this terrible dirt which so materially assists the spread of plague. Their mud huts, accommodating as they do many too many persons, are frequently in an indescribable state of filth, while a rooted aversion to fresh air adds another factor in favour of the ubiquitous microbe. Cow-dung is used universally as flooring, and in many instances as walling too. Even Europeans have their verandahs floored with cow-dung, the surface of which is repeatedly renewed by women, who spread it flat with their hands. It is not nearly so unpleasant as it sounds, and when dry is quite inoffensive.

Having left Satara, which is a semi-fashionable hill station, much frequented in the rainy season, I went down south to Hubli. Here I met Leumann and Winter, both suffering from overwork, as the plague was raging fiercely, and they were miserably understaffed, a fact which we could never get the Government to appreciate; and, indeed, they did not seem to have the men.

I had not been long at Hubli, where I was principally engaged on inoculation work, before I had to go off to Gadag, a smaller town nearer the Mysore border. Although there was no plague there, there was plenty of cholera—nearly twenty cases a day. I am not sure which is the worse, but on the whole I prefer the plague. It was while I was at Gadag that I had the satisfaction, if that is the proper term to use, of discovering what was perhaps the worst plague-infected village in the whole of India; and with a description of that village I will close this article.

Hire-Handigol ("hire" is the Canarese for "great") is one of two adjacent villages in the southern Mahratta country, about nine miles from Gadag, and off the main road. Its normal population is between 500 and 1000, all of whom eke out a precarious existence by cultivating the black cotton soil of the neighbourhood. It lies at the foot of a small hill, which rises abruptly from the dead level of the surrounding plain. A little less than half a mile away a small river or nullah wends its sluggish course to form one of the countless tributaries of the mighty and sacred Krishna. Few trees exist near this dreary spot, the only vegetation, excepting the various crops of jaivari, bajari, cotton, &c., being some stunted palms growing at the edge of the nullah, and affording shelter for a few flocks of seven-sisters or an occasional resting-place for the inevitable crow.

Having learned that all was not quite right in the village, I proceeded from Gadag accompanied by Mr. Vincent, Assistant District Superintendent of Police, and Mr. Bharade, District Deputy Collector, the latter a Brahmin gentleman of considerable local importance. I had been informed that cholera was raging in the two villages, but suspecting the truth of this assertion, I, in consultation with the two gentlemen named above, thought it advisable to see for myself. To within a mile of Hire-Handigol we travelled in dumnies (a kind of closed cart drawn by two bullocks), and then on foot ascended the small hill previously mentioned. As far as the eye could reach, the lone and level plain stretched far away, save where the Dumble range broke the even monotony of the landscape. Hire-

Handigol lay immediately at our feet, seemingly a village of the dead, for we could see no signs of life in its irregular streets, nor was there any smoke rising from the numerous and closely crowded mud and stone huts. A little way down the scarp of the hill a flock of vultures were disputing together, while close by two or three gaunt and evil-looking pariahs were engaged in devouring something or other, only desisting to growl threateningly on our approach. Quickly descending we neared the village, only to be greeted by the most awful and insinuating smell; so bad was it that I, who thought myself inured to such things, instinctively clapped my handkerchief to my nose, while Bharade took long and copious sniffs at a ball of naphthaline which he always carried with him. The smell persisted, but we soon had other matters still more gruesome to distract our attention. For presently I stumbled over a human skull, and then another, and then several strewn here and there with other remains, as also the clothing in which the dead had been cast out. Now the full significance of the vultures and pariahs came over us, until with a shudder we turned away to complete our unsavoury task. Passing into the village itself, we were met by some Sepoys whom we had sent on in the early morning in anticipation of any trouble. A few frightened villagers also appeared; from one of them we managed to extract some sufficiently melancholy information. The pestilence, he said, had begun about six or eight weeks previously; at first it did not result in more than one or two deaths daily, but quickly gathering force it made its presence felt in no half-hearted manner. The miserable people fell ill, and died in tens and twenties; many fled, but many also remained, only to serve as fresh victims to the rapacity of their terrible visitor. During the previous ten days about one hundred had perished, including the patel or village headman. This, in a population when we arrived of a little over 300, serves to illustrate what plague can do when it is so minded. I was further informed that at the time there were between thirty and forty persons lying ill in their huts. We at once proceeded on a systematic inspection of the whole village. Never will I forget that ghastly procession. Leading the way and flanked by two Sepoys walked the acting patel, then we came, and after us a motley and terrified crowd of inhabitants, many of whom had already the plague in them. Hut after hut I entered—pitch-dark, loathsome, and stinking hovels. The dead and dying lay in all directions, hardly a corner but had its stricken occupant. In one, I remember, I stumbled over a dead baby in the doorway, and falling forward, only saved myself from going full length by my outstretched hands impinging against its dying mother's prostrate form. Some of the scenes were too revolting to appear in print, but those of you who have met with a really bad case of general paralysis in the third stage will understand what I mean. Frequently I had to rush out of the germ-laden atmosphere gasping for breath, although I smoked cigarettes persistently throughout my inspection. Most of the cases were of the bubonic type; several, however, were not, and I saw two or three at least who showed extensive hæmorrhages. Some died when I was looking at them,—partly, I am sure, from fright, as in the endeavour to sit up or get out of the way the heart failed to bear the sudden and extra strain, with an immediately fatal result. The mortality had been so high that there had been no time to burn or bury the dead, hence the gruesome sights we had seen outside the village.

There is, I believe, a ludicrous side to nearly everything, and even these horrors proved no exception to this rule. Whenever I came out of an infected hut I simply remarked "Plague," for the benefit of a recording clerk. Its effect was most profound, especially on Bharade, who had before then never been intimately in contact with infection. He visibly paled and retired a few steps, muttering in a mixture of Hindustani and English; while Vincent, who possessed a remarkable fund of medical knowledge, pretended to find various malignant microbes upon his own and Bharade's person. These microbes at last got so large, nearly an inch long, that Bharade began to see the joke, and finally smiled in I-would-I-were-out-of-it kind of way.

So much for Hire-Handigol. The necessary measures were taken, and shortly I believe the epidemic was stayed. Too late; Southern India had become already infected, and now it is as bad there as it ever was further north.

Case of Severe Poisoning by Antidiphtheritic Serum.

By J. D. RAWLINGS, M.B.Lond., formerly House Physician, St. Bartholomew's Hospital.

DR. HERRINGHAM, in his article on "The Serum Treatment of Diphtheria" in *Allbutt's System of Medicine*, says: — "In some cases the injection of serum is followed by a rash, erythematous or urticarious, upon the skin. In a few cases there is itching, but it has no other ill effect, and it passes off sometimes within a few hours, sometimes within a few days. Less often—we have never seen it—there is pain and swelling in some of the joints, which is also transient."

Messrs. Burroughs and Wellcome, in the printed directions which they supply with their serum, state in capital letters, "The serum can do no harm, so may be used freely." The above statements are quite in accordance with my own small experience of antitoxin rashes, due either to antidiphtheritic serum or to tuberculin. I was therefore considerably taken aback when a single injection of antitoxin in one of my cases was followed by an illness far more severe than the diphtheria for which it was given. Such cases are, I hope, sufficiently rare to justify the publication of such a one in detail.

G. H—, æt. 8, male. Family history and past history unimportant. History of present condition, related by the father, who is a medical man spending his holiday in Dorking:—Patient was quite well until September 21st, when he was "not quite himself." Morning temperature 99° F. Was kept at home.

September 22nd.—Was apparently well again, but the morning temperature was again 99° F. Spent the morning bicycling.

September 23rd.—Complained of slight sore throat, and was first seen by me. Morning temperature 99·6°, rising during the day to 102·8° in the evening. Neither pulse nor respiration rate was increased out of proportion to the temperature. Tongue very slightly furred; fauces red and somewhat swollen; mucus in the pharynx. On each tonsil was a single patch, the colour of wet wash-leather,

about the size of a silver penny. No exudation on soft palate. Very slight enlargement of glands at left angle of jaw; none on the right side. A careful systematic examination of the boy revealed no other physical signs of disease anywhere. There was no albumen in the urine. A swab taken from the throat had upon it a small fragment of membrane, and Dr. Drysdale subsequently reported that the swab contained many diphtheria bacilli. A minimum dose (7 c.c.) of Burroughs and Wellcome's serum was injected deeply into the right buttock. The serum had been kept for two months in a very cold dark cellar, and was quite clear. The skin was washed with soap and water before the injection. Every part of the syringe had been boiled since it was last used. No covering was applied to the puncture.

September 24th.—Temperature normal in the morning, but rose to 100° F. in the evening. Fauces unaltered.

September 25th.—Temperature was normal in the morning, and remained so until October 2nd. The membrane had entirely disappeared on September 28th, and the redness of the fauces was diminishing. From the beginning the fauces were swabbed twice daily with glycerine and perchloride of mercury 1 in 1000. By the end of September patient was regarded as quite convalescent, and was going out a little each day.

September 30th.—A few diphtheria bacilli were found in a swab from the throat.

On October 2nd, on returning from his walk, his temperature was found to be 99°.

October 3rd.—Temperature 99·2° in the morning, and 100° in the evening. There was a slight increase in the glandular enlargement, and some tenderness at the left angle of the jaw. The appearance of the fauces was unaltered. There was a slightly raised patch of erythema, about two inches in diameter, surrounding the seat of the antitoxin injection on the right buttock.

October 4th.—Temperature 101° to 102°; pulse in the evening 120; respiration 24. No physical signs in the chest either now or at any future time. There was a blotchy erythema over the lower extremities and lower part of the back, which increased during the day. The skin was intensely irritable, and as well as the morbilliform rash there was a good deal of urticaria, to which the boy is liable. The fauces were redder than they had been, and there was again some slight swelling.

October 5th.—Temperature 100·2° to 102·2°; pulse 120 to 132; respiration 24. Fauces better than yesterday. Marked glandular enlargement and tenderness at angle of jaw. The rash is spreading up the back. In many places it is markedly circinate. It shows no preference for the flexures of the joints, being, indeed, quite absent from the popliteal spaces. It is very profuse on the arms and hands. There is one isolated patch over the left mastoid process. The face is clear. Very slight injection of conjunctivæ, and some swelling of nasal mucous membrane. Tongue scarcely furred. Appetite very poor. Bowels open. No headache. Lungs *nil*. Faint hæmic murmur at apex of heart.

October 6th.—9 a.m., child looks and feels better. Temperature 99°; pulse 120, good volume and tension. Apical heart murmur has disappeared. Throat as at last note. The rash has extended to the top of the back, and is quite confluent on the lower parts of the legs. Was very restless till 1 a.m. this morning, when he had half a drachm of "bromidia," and afterwards slept well; some constipation. 9 p.m., temperature 103°; pulse 132. Child very peevish, and complains bitterly of itching everywhere, and of pain in arms, legs, and hands; this is so severe that he cannot be moved without crying out. The pain is not specially in the joints, and the latter are not swollen. The pruritus is most severe on the soles of the feet. The face is now covered with a blotchy, slightly raised erythema, which is not circinate. The skin is slightly puffy everywhere. Tongue slightly furred. Constipation has not yet yielded to treatment. Heart, lungs, and abdomen normal. There has been no rigor. Complains of slight pain above pubes, but the bladder is empty. Sponged for a quarter of an hour, during which temperature fell to 102°, and subsequently to 101·5°, and patient seemed more comfortable; but there was no fall in pulse rate.

October 7th.—Temperature 103·6° to 102·8°; pulse 120; respiration 24. Had four or five hours' sleep, and took food well in the night, but has been refusing it to-day. Is slightly brighter than yesterday. Pain much diminished. Rash has faded markedly on trunk and limbs, but not on face. Injection of conjunctivæ very marked. The condition of the eyes, throat, nose, and skin of face is very like that of measles. Urine contains a trace of albumen. In the evening the case was seen by Dr. Barlow, who had no doubt that the symptoms were due to antitoxin, and gave a favorable prognosis.

October 8th.—Temperature 99·8° all day; pulse 110 to 100; face flushed, but there is nothing that can be recognised as a definite rash. Everywhere else the rash has disappeared, leaving little or no pigmentation.

From now all the remaining symptoms rapidly abated. The temperature was subnormal on the morning of the 9th, and there was no return of fever. No bacilli were found in a swab sent to the Pathological Laboratory on October 12th.

From the point of view of the general practitioner, at least, it is a very important fact that antitoxin *may* cause an illness so severe that the patient's life appears to be in danger. In this particular case the father of the child (himself a medical man) was fully convinced that the patient was going to die; and although so gloomy a view was never to my mind justified, one could not but feel extremely anxious on October 7th, when the morning temperature was 103·6°, the pulse 120, and the child beginning to refuse his food, in spite of the fact that the rash was disappearing. Very striking points in the case are the unusual severity of the pains in the limbs and the fact that the pain was not specially in the joints, nor were the joints swollen. Knowing the history of the case, the diagnosis was simple enough; but had one seen the case for the first time on October 7th, it might well have been mistaken for measles, the chief diagnostic point being that the rash was fully out on the face and fading on the rest of the body. From a septic process it was distinguished by the length of the incubation period. Why is it that illnesses caused by the injection of serums have definite incubation periods? The ordinarily accepted explanation of the incubation period of zymotic diseases does not apply to serum fevers where no micro-organisms are introduced.

Case of Alleged Self-inflicted Skin Affection.

Read at joint meeting of the West Somerset, and Dorset and Hants branches of the B. M. A. at Yeovil, October 18th, 1898.

By MARK R. TAYLOR.

THE patient is a lady of about 40, unmarried, and of no occupation. She has suffered from the eruption for four or five years. I first saw her two and a half years ago, when she complained of a painful affection of the skin on the right wrist. A patch of skin about 2 to 3 inches long by ½ to 1 inch broad over the back of the wrist was discoloured, the colour running from pink at the edges to dark purple inside, while in the centre was a shallow ulcer. There were shallow sunken scars on the left wrist, and one or two ulcers more or less healed on the right. Some months later the eruption appeared higher up the arm, and by degrees covered the whole of the front of the elbow-joint, where a considerable amount of ulceration took place. Then the upper part of the left chest and forehead were attacked.

About this time severe neuralgia "in the back of the eye" came on; the patient had been accustomed to suffer from this previously to my attending her, and be relieved by hypodermic injections of water. This treatment I continued at intervals. Soon after the neuralgia came on the rash appeared just over the left eye, invading the eyebrow. About this time I began to suspect its origin. The front of the right upper arm was then attacked by the rash. I asked Dr. Cave, of Crewkerne, to see her with me, and two days previous to his coming I covered the part affected with lint and strong strapping, so as to take in a margin of an inch all round. When we saw the patient we found a fresh outbreak on the surface beyond the lint, leaving a clear gap corresponding to the inch interval, while the new rash followed the edge of the lint. Dr. Cave was of the same opinion as myself as to the origin of the rash. The eyebrow was then again affected, and the neuralgia demanded more and more frequent injections of morphia; consequently I gave injections of plain water, when she required any, for a period of a year, which were uniformly successful, giving generally twelve, and in one case fifteen hours' sound sleep.

About four months ago the patient had an attack of hysterical aphonia, which, however, soon cleared up on the use of a battery. The rash then appeared over the trachea, and extended down the sternum. I drew a line of caustic round this, said the rash could not spread over it, nor did it. The rash then began again a few inches below the angle of the left jaw, and spread from the clavicle to the edge of the sterno-mastoid, and down the arm as far as the insertion

of the deltoid. I again used the caustic, but my patient had found out it was common caustic I used, and expressed a doubt as to how much it would now stop the spreading. In consequence, in a couple of days the rash had jumped over the line, and there were patches formed between the latter and the border of the axilla. The surface affected was ten inches by six inches in its longest diameters.

The rash appears as follows:—for about twenty-four hours stinging pain is felt at some point, the skin then gets pink and by degrees purplish, followed later on by desquamation in slight cases, or blistering and ulceration in the more severe.

My reasons for believing the rash to be self-inflicted are—

(1) The rash has never appeared on any spot that cannot be easily got at.

(2) The character of the rash, which resembles none that I can find described.

(3) The way the rash spread round the edge of the lint.

(4) The way the rash jumped the caustic line.

(5) The rash follows no definite course with regard to body surfaces or nerve distribution.

(6) The neurotic character of the patient.

With regard to the treatment, I think I may say I have tried everything that ever does good in skin affections, but with no success. When any ulceration or raw surfaces appear, I give her dressings of iodoform and eucalyptus ointment, strong enough to make her a very unpleasant companion; but she has used this for months without appearing to mind. As to the cause I am inclined to believe some vesicant is used, but have never been able to trace anything microscopically or otherwise. Unfortunately, family circumstances prevent my getting her to undergo Weir-Mitchell treatment or any strict watching, while the sympathy of her family effectually stops any aid I might expect from them.

Since writing the above the patient has been away for a month, and has come back with severe ulceration of the skin over the left elbow, which I am afraid will cause enough cicatrisation to interfere with the movement of the joint. This ulceration took place before she consulted a doctor, who at my suggestion covered up the arm securely, with the result that the rash spread no more.

Since her return I have, at Dr. S. West's suggestion, painted the places as soon as they showed or became painful with collodion. This effectually prevented any further progress towards ulceration. I have also retained the dressings in place with starched bandages, and the rash has appeared at the edges of, or in any gap in the bandage.

I have also learnt that five-and-twenty years ago the patient had an hysterical knee-joint, which was cured by an anæsthetic.

I have thought the case worth reporting, owing to the large area over which the rash spreads, the great pain and discomfort the patient must suffer, and the long time that the disease has lasted.

South Petherton, Somerset.

A Case of Dislocation of the Head of the Femur into the Perinæum.

By G. S. HAYNES, M.R.C.S., L.R.C.P., late Acting House Surgeon, West Kent General Hospital.

A YOUTH æt. 18 years was admitted to the West Kent General Hospital, Maidstone, on October 3rd, 1898, with the following history:

He was playing football, and whilst running quickly with a long stride after the ball was pushed over and fell heavily. On attempting to rise he experienced great pain in the right hip-joint, and found he was unable to bring his legs together.

On examination the right thigh was found to be completely abducted, flexed, and everted, forming a right angle with the trunk. The head of the femur was felt in the perinæum behind the scrotum, and there was a very marked depression over the normal situation of the great trochanter.

An unsuccessful attempt to reduce the dislocation by manipulation was made, so chloroform was administered.

The thigh was then flexed on the abdomen, so that the knee nearly touched the chest wall, then adducted, internally rotated, and extended, with the result that the head of the bone suddenly and easily slipped back into the acetabulum.

I am indebted to Mr. A. H. B. Hallowes, surgeon to the hospital, who reduced the dislocation, for his permission to publish this note.

Notes.

THE 34th volume of the 'St. Bartholomew's Hospital Reports' will appear early in January next, under the joint editorship of Dr. Norman Moore and Mr. D'Arcy Power. It will contain papers by Sir Thomas Smith, Mr. Henry Power, Mr. Marsh, Mr. Butlin, Mr. Walsham, and other members of the medical and surgical staff. The subscription list is not worthy of the large hospital whose practice and progress it is the business of the Reports to record, nor is it enough to maintain the Reports at the highest level of excellence. It is hoped, therefore, that intending subscribers will send in their names without delay to the librarian, Mr. P. F. Madden. The subscription price for each volume remains at 6s., the price to non-subscribers being 8s. 6d.

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SIR DYCE DUCKWORTH has retired from his position as examiner for the Navy Medical Service, a post which he has held for eight years.

* * *

THE Mid-Sessional Address will be delivered before the Abernethian Society on Thursday, January 12th, 1899, by Mr. Berry. He has chosen as the title "Dressers and Dressing." This is a subject which Mr. Berry has made peculiarly his own; the *genus* "Dresser," all the varieties and the habitats thereof have been carefully studied by him, and it is rumoured that he has several unique examples in his extensive collection. Mr. Berry may be sure of an audience and a hearty welcome.

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MR. PERCY FURNIVALL has been elected assistant surgeon to St. Mark's Hospital.

* * *

MR. WILLETT has kindly pointed out an oversight in our note of the October issue referring to the recent cleaning of the Hogarth pictures. We suggested the possibility that the wealthy lady who forms a prominent figure in the "Pool of Bethesda" suffered from a functional paralysis. On close inspection, however, one distinctly sees upon her skin the typical character and distribution of the eruption of psoriasis. It is interesting, therefore, to note in passing that Hogarth represents two distinct forms of the (ancient) genus *Lepra* in this picture. We wish to thank Mr. Willett for his correction, and would point the obvious lesson that our readers should avail themselves of a sunny day to get an adequate view of the paintings.

* * *

MR. H. WILLIAMSON has taken the degrees of M.A., M.B., B.C. at the University of Cambridge.

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IN the innocent days of childhood a familiar form of playing card gave a warning as to the drawbacks to the life of a medical man. The picture represented a weary

mortal, attired in airy night garments, with candle in hand, answering a night call at his door. Below were the words "Who would be a doctor?"

Readers of this JOURNAL decided that, in spite of the many known hardships, they would enter the profession. They were soon met by a quite unexpected difficulty. As students they have all been oppressed with the overwhelming amount of medical literature, and notwithstanding sturdy efforts to master all branches of their profession, even the best have found it utterly impossible to digest even a tithe of the works published. A glance through the advertising columns of the journals fills one with nothing short of dismay. Every branch of medicine and surgery is being minutely investigated, and the results published. Small subjects, which a few years ago were exhausted in five or six pages of the standard text-book, are now treated by bulky volumes which almost make the student feel the futility of striving. A recent number of the *British Medical Journal* contained advertisements of many such books. One writer devotes 440 pages of crown octavo to "Tests and Studies of the Ocular Muscles." Another discusses through 240 pages of royal octavo the "Ferment Treatment of Cancer and Tuberculosis," and a third investigator requires no less than 926 pages of royal octavo to record what is known about the "Traumatic Separation of the Epiphyses." Numerous other examples could be quoted of bulky volumes dealing with recognised and well-defined branches of knowledge. But a recent publication simply overflows all known bounds, and devotes 965 pages of imperial octavo to the study of "Anomalies and Curiosities of Medicine."

* * *

SOLOMON of old complained that "of making books there is no end, and much study is a weariness of the flesh." If such a wise man in his day suffered, surely words fail to describe the sorrows of the poor medical student of to-day. It has been said that "it is in literature as in finance, much paper and much poverty may co-exist." Can this apply to medical literature?

* * *

THE above had already been written when we received the first two issues of 'The Medical and Surgical Review of Reviews,' edited by Nathan Boyd, M.D. This is a praiseworthy attempt to cope with the enormous mass of medical literature by abstracting it and presenting it in a form capable of being assimilated by the busy general practitioner. At present the scheme is somewhat tentative, but when it is in full working order it should prove of considerable value. Those contributions to the literature of the month which are deemed most important form a series of leading articles, and are followed by a comprehensive series of brief abstracts. The annual subscription has now been fixed at one guinea, and the magazine appears monthly.

OUT of five Gold Medals awarded at the recent London M.B., four have been given to two Bartholomew's men, Mr. T. J. Horder and Mr. J. P. Maxwell. We congratulate them heartily upon their success. The former has received a Medal in each of the three subjects of the Honours Examination—a record performance since 1881,—the latter the Scholarship and Medal in Obstetric Medicine.

* * *

As this is the sixth successive year in which the Scholarship in Obstetric Medicine with its accompanying Gold Medal has fallen to us, it is interesting to recall those who have brought such credit to the School. 1893—H. O. Davies. 1894—W. E. Lee. 1895—S. Gillies. 1896—W. d'Este Emery. 1897—E. J. Toye.

* * *

The following is the list of Honours:

UNIVERSITY OF LONDON.—*M.B. Honours Examination: Medicine.*—Gold Medal, T. J. Horder. *Obstetric Medicine.*—Scholarship and Gold Medal, J. P. Maxwell; Gold Medal, T. J. Horder. *Forensic Medicine.*—Gold Medal, T. J. Horder.

* * *

MR. H. G. READ has been reappointed an Assistant Dental Surgeon.

* * *

MR. A. GRANVILLE has been appointed Senior Assistant Anæsthetist, *vice* Dr. B. Collyer, resigned.

* * *

MR. W. F. CROSS has been appointed Junior Assistant Anæsthetist.

* * *

WE learn that Dr. West has resigned the post of Physician to the Skin Department.

* * *

THE election of a Casualty Physician has been postponed for three months.

* * *

ON the evening of October 7th, 1898, at the Holborn Restaurant, George Street, Sydney—a name strongly reminiscent of the old days,—the first annual dinner of Bart.'s men resident in New South Wales was held. The chair was taken by Dr. Milford, a veteran whose Bart.'s days date back nearly fifty years, and who well remembers Sir George Burrowes and Sir William Lawrence. Dr. Jenkins filled the vice-chair. The toast list comprised three—the Queen, Bart.'s by Dr. Jenkins, absent friends by the chairman,—all drunk with much enthusiasm and amidst strong expressions of affection for the old School and its staff. Drs. Gudden, Hughes and Mr. Woodhouse by their singing contributed much to the success of a very pleasant evening. The latter gentleman rendered a song specially composed in honour of "Bart.'s."

Great credit is due to the Hon. Secretary, Dr. Mailler Kendall, for the method in which he managed and carried out the dinner—a function which will do much to bring

Bart.'s men together, and establish a salutary *esprit de corps* among them. The menu card was adorned with the Bart.'s shield, and a reproduction of the old Priory of St. Bartholomew. Below are the names of those present.

Drs. F. Milford, R. J. Allun, Thomas Pickburn, S. T. Knaggs (visitor, editor of *A. M. G.*), Fourness Barrington, Sinclair Gillies, H. Guy Warren, E. J. Jenkins, C. Dugwal Clark, T. Mailler Kendall, F. R. Woodhouse (guest), A. Maitland Gudden, S. H. Hughes, two Bart.'s men resident in New South Wales.

C. B. Pym and H. G. Wright were unavoidably absent.

Amalgamated Clubs.

CRICKET CLUB.

AT a General Meeting held in the Smoking Room on Wednesday, October 26th, Mr. E. F. Rose in the chair, the following gentlemen were elected to serve as officers for the ensuing season:

President.—Dr. Church.
Captain, First XI.—H. W. Pank.
Secretaries, First XI.—C. H. Turner, H. E. G. Boyle.
Captain and Secretary, Second XI.—C. H. Hawes.
Committee.—E. F. Rose, J. A. Willett, W. H. Randolph, J. C. Sale, H. E. Scoones, L. B. Bigg.

RUGBY FOOTBALL CLUB.

After the football match on November 30th, St. Bartholomew's Hospital *v.* the Hastings and St. Leonards Football Club, the Old Bart.'s doctors who practise in Hastings and its neighbourhood entertained for the sixth time the teams at a "high tea" at the Castle Hotel, Mr. T. H. Wadd in the chair.

The company, which numbered 130, included nine of the eleven "hosts," viz. Dr. Brodie (Battle), Mr. C. Christopherson, Mr. E. J. Deck, Mr. C. B. Gabb, Mr. L. Jowers, Dr. H. Marshall (Bexhill), Dr. Trollope, Mr. Wadd, and Dr. Scarlyn Wilson, Mr. C. A. Coventon and Mr. Perham Taylor being unable to attend. There were also present the Mayor of Hastings, the two teams, and a most representative gathering of the many sporting clubs of the town, who were invited to do honour to the old Hospital of St. Bartholomew.

After a substantial cold collation, which was done ample justice to, Mr. Wadd, who was very warmly cheered, proposed "Success to St. Bartholomew's Hospital Football Club." He congratulated the Hospital on its victory that afternoon (2 goals to 1), and then expressed his great pleasure in seeing once again a team from the Hospital, and said how glad he was to hobnob once more with men from his old school.

The toast was most warmly received, and the Vice-Captain (Mr. Bostock) replied. He said that they had, as they always did have at Hastings, a good game. Of course he was glad they had won. He regretted the absence of their Captain, who was not free to play in Wednesday matches. He hoped that the very kind wishes that had been expressed might help them in their Inter-Hospital Cup ties, and so uphold the reputation of the grand old Hospital to which they belonged. He most heartily thanked the Old Bart.'s doctors for their capital entertainment.

Dr. Scarlyn Wilson next gave "Success to the Local Club." This he supported in an amusing speech, which was well received. He coupled the toast with the Hastings Captain (Mr. G. Bond), whom he called the "Sirdar" of the local forces. He congratulated the club on its flourishing condition, its good form, its freedom from debt, its balance at the bank, and the largely increased attendance of the public at its matches.

Mr. G. Bond, who was also cheered, thanked the company, saying that the Bart.'s match was always looked forward to as one of the best of the season. He reminded the company that the club was the "runner up" last season for the Senior Sussex Cup, and this year they very much hoped to bring the cup home to Hastings.

In response to loud calls and much applause, the President of the Club (Mr. C. B. Gabb) rose and said that this tea party was always a red letter day in his calendar. He thanked them for the splendid reception they had given him as President of the Hastings and St. Leonards Football Club.

Mr. N. A. Hardwich next proposed the last of the three toasts allowed at this festival, "Our Hosts." This he did briefly and to the point, saying how much local football gained year by year from the hospitality of the Old Bart.'s doctors.

Dr. Trollope who replied received a very hearty greeting, and his remarks were much cheered. He said that he had been born too soon for football. When he was at the hospital (1856) there were no clubs. He supposed to-day the best team had won, and the game had been a spirited one. He was sure that the Hospital would always be able to send a doughty eleven to meet the local notables, and he was positive that they would invariably receive a hearty welcome.

The Bart.'s team had to leave by the 7.50 train, so the time was short; but in between the speeches a most capital entertainment was given. Mr. Wallis Arthur (comic) and Mr. Foxton Ferguson (bass) both came from London on purpose to sing, and their efforts were greatly appreciated. Mr. H. C. Willmott gave a reading from Rudyard Kipling, and Dr. Redmayne and Mr. Sorrell sang a duet. Grace was said by the Rev. F. W. Smythe, and the accompanist was Mr. H. Goss Custard, Mus.Bac.Oxon.

After "God Save the Queen" the Bart.'s men made a dash for the train. Both guests and hosts agreed that this tea and smoking concert in no way fell behind those given in previous years, the company being most enthusiastic and the whole affair successful in every way, and it goes to prove strongly that as each year adds to the number that divides the Old Bart.'s doctors from their student days, it in no way slackens their love and affection for the School and Hospital of St. Bartholomew.

ST. BART.'S (A) *v.* CIVIL SERVICE (A).

Played at Richmond on Saturday, October 15th, when the A team opened what promises to be a highly successful season by a win of 5 goals 3 tries (33 points) to *nil*.

Team.—C. L. Nedwill (back); H. W. Pank (captain), W. S. Danks, E. W. Price, C. S. Wakley (three-quarters); G. C. Marrack, H. B. Ash (halves); J. M. Plews, H. E. Stanger-Leathes, N. Maclaren, E. C. Hodgson, F. Harvey, H. M. Huggins, H. Mills, L. Arnould (forwards).

ST. BART.'S (A) *v.* UNIVERSITY COLLEGE.

Played at Acton on October 22nd, and won by 2 goals 6 tries (28 points) to *nil*.

Team.—C. L. Nedwill (back); H. W. Pank (captain), C. Dix, A. J. Spreckley, H. Slater (three-quarters); N. M. Wilson, H. S. Ward (halves); H. G. Boyle, F. Harvey, E. C. Hodgson, H. M. Huggins, H. T. Wilson, L. Arnould, E. G. D. Milsom, J. D. Riddle (forwards).

ST. BART.'S (A) *v.* UNIVERSITY COLLEGE SCHOOL.

Played at Winchmore on October 26th, resulting in an easy win for the Hospital by 5 goals 4 tries (37 points) to 1 goal 1 try (8 points).

Team.—C. O'Brien (back); H. W. Pank (captain), S. Mason, A. J. Spreckley, L. M. Rosten (three-quarters); E. C. Mackay, H. S. Ward (halves); H. G. Boyle, H. E. Stanger-Leathes, E. C. Hodgson, F. Harvey, H. M. Huggins, H. T. Wilson, L. Arnould, E. G. Milsom (forwards).

ST. BART.'S (A) *v.* OLD CHARLTONIANS.

In this match, on November 5th at Charlton, the A team met with their first reverse by 3 tries (9 points) to *nil*.

Team.—C. L. Nedwill (back); H. W. Pank (captain), C. Dix, E. W. Price, C. S. Wakley (three-quarters); E. C. Mackay, H. S. Ward (halves); J. M. Plews, H. G. Boyle, F. Harvey, H. E. Stanger-Leathes, E. C. Hodgson, L. Arnould, E. G. Milsom, L. M. Rosten (forwards).

ST. BART.'S (A) *v.* UPPER CLAPTON (A).

On November 12th, at Upper Clapton, a fast and even game ended in a win for Bart.'s by 1 goal (5 points) to *nil*. The try was obtained by M. B. Scott just at the corner flag, Pank converting by a magnificent kick.

Team.—H. W. Pank (captain) (back); W. H. Scott, L. M. Rosten, A. J. Spreckley, A. B. Slater (three-quarters); E. C. Mackay, H. S. Ward (halves); M. B. Scott, H. E. G. Boyle, H. E. Stanger-Leathes, N. Maclaren, E. C. Hodgson, H. M. Huggins, H. Mills, E. G. D. Milsom (forwards).

ST. BART.'S (A) *v.* MERCHANT TAYLORS' SCHOOL.

This match at Winchmore Hill resulted in a loss by 1 goal 3 tries (14 points) to 2 tries.

Team.—C. L. Nedwill (back); E. W. Price, L. M. Rosten, A. B. Slater, C. S. Wakley (three-quarters); W. H. Scott, E. C. Mackay (halves); H. E. Stanger-Leathes, N. Maclaren, E. C. Hodgson, R. Im Thurn, H. T. Wilson, W. L. Davies, H. M. Huggins, L. Arnould (forwards).

ST. BART.'S (A) *v.* LONDON IRISH (A).

This match took place in grand weather on the Irish ground at Herne Hill. Our opponents turned out to be a keen but unskilled team, and the game proved an easy win for the Hospital by 2 goals 5 tries (25 points) to *nil*.

Team.—A. B. Slater (back); H. W. Pank (captain), L. M. Rosten, G. C. Marrack, C. G. Martin (three-quarters); E. C. Mackay, N. M. Wilson (halves); M. B. Scott, F. Harvey, R. Im Thurn, E. C. Hodgson, H. H. Riddle, H. M. Huggins, H. Mills, L. Arnould (forwards).

ST. BART.'S (A) *v.* GUY'S (A).

This match was spoilt by the state of the ground, the game being played in the rain. A very even "scrum" game resulted. Guy's scored rather luckily just by the corner flag on the call "No side." No goal resulted, and the game ended in a win for Guy's by 1 try to *nil*.

Team.—A. B. Slater (back); H. W. Pank (captain), G. C. Marrack, L. M. Rosten, C. G. Martin (three-quarters); N. M. Wilson, E. C. Mackay (halves); M. B. Scott, H. E. G. Boyle, H. E. Stanger-Leathes, F. Harvey, G. M. Levick, R. Im Thurn, H. M. Huggins, E. G. D. Milsom (forwards).

RESULTS.

So far the results are as follows:—Played 8, won 5, lost 3; points for 135, points against 34.

ASSOCIATION FOOTBALL CLUB.

ST. BART.'S *v.* BARNES.

This match, fixed for Wednesday, October 26th, was unfortunately scratched by our opponents.

ST. BART.'S *v.* OLD CRANLEIGHANS.

This match was played at Winchmore Hill on Saturday, October 29th, and resulted in an easy win for the Hospital by 5 goals to love. Willett won the toss, and selected to play from the pavilion end. An energetic game ensued, both goals being visited in turn. The home forwards, however, broke away, and O'Brien scored the first point for Bart.'s. Almost immediately after, from a good run and pass by Ward, Willett was able to beat the opposing custodian with a low shot.

On changing ends the Hospital did very much as they liked. After some desultory play, O'Brien ran through the opposing backs and scored; the remaining two goals were got by Willett and O'Brien. For the Hospital, L. Orton and Bates were the best of the back division. Team:

H. H. Butcher (goal); T. H. Fowler, L. Orton (backs); E. H. Scholefield, A. H. Bostock, T. Bates (halves); H. N. Marrett, J. A. Willett, C. O'Brien, V. G. Ward, G. H. Orton (forwards).

ST. BART.'S *v.* RICHMOND.

This match was to have been decided on Wednesday, November 2nd, at Richmond; but, owing to our opponents being obliged to re-play a Cup tie, the match had to be scratched.

ST. BART.'S *v.* FOXES.

Played on Saturday, November 5th, at Winchmore Hill. Bart.'s were not playing their full strength, but the game resulted in a very easy win for the Hospital. Result: 8 goals to *nil*.

The game was not started till very late, owing to the late arrival of the referee. The home forwards, starting the game, soon got together, and G. H. Orton scored the first point for Bart.'s. Almost immediately Scholefield beat the Foxes' goal-keeper again with a splendid shot, which just dropped over his head, and shortly after Ward added another goal to our score.

At half-time the score was—Bart.'s, 3 goals; Foxes, *nil*. The latter half of this game was almost entirely confined to our opponents' quarter, Butcher, in goal, only touching the ball once. The remainder of the goals were scored by Ward (2) and Marrett (1). Team:

H. H. Butcher (goal); T. H. Fowler, L. Orton (backs); E. H. Scholefield, A. H. Bostock, C. H. Fernie (halves); H. N. Marrett, V. G. Ward, C. O'Brien, T. Bates, G. H. Orton (forwards).

ST. BART.'S *v.* IPSWICH.

This match was played at Ipswich on Saturday, November 12th, before a numerous attendance, and after an exciting and keenly contested game the result was a victory for the Hospital by 4 goals to 3. H. E. Thomas unfortunately missed his train, but Ipswich very kindly found us a substitute, who played a sound game throughout.

Shortly after the commencement of the game Ward and O'Brien broke away, and finishing up a good combined run, O'Brien put the ball into the net, thus scoring our first point. Ipswich made strenuous efforts to equalise, and a few minutes before half-time added a couple of goals in quick succession. At the interval the score was—Bart.'s, 1; Ipswich, 2.

In the second portion the Hospital were doing all they could to get on terms, and the opposing goal-keeper was continually being called on to save good shots from Ward, Willett, and Bostock. From a run by the home forwards the ball was taken down to our goal, and Gardiner, the inside right, scored a third point for Ipswich with a fast low shot, which it was impossible for Butcher to have saved. After this play was chiefly confined in front of the Ipswich goal; but the back division was equal to the attacks made by the Hospital until Ward, who had been playing a splendid game, beat the home custodian with a side shot. Shortly after Bostock put in a very hot shot, which unfortunately hit O'Brien on the head in the mouth of the goal, and the ball rebounded into play. The former, however, soon obtained possession again, and this time proved successful, thus equalising the score. Within a few minutes of time Marrett added the fourth goal. Team:

H. H. Butcher (goal); T. H. Fowler, L. Orton (backs); E. H. Scholefield, A. H. Bostock, T. Bates (halves); H. N. Marrett, J. A. Willett, C. O'Brien, V. G. Ward, A. N. Other (forwards).

ST. BART.'S *v.* REIGATE PRIORY.

In this match, played at Reigate on Saturday, November 19th, Bart.'s had by no means their full team, but the game terminated in a satisfactory win for us by a rather narrow margin of 1 goal to love. Our opponents, winning the toss, selected to play down the hill. O'Brien started the game for the Hospital, and the forwards, quickly getting together, attacked the Reigate goal vigorously, but, however, without success. In turn the opposing forwards broke away, but our back division was equal to the occasion, and Butcher brought off a splendid save from a good shot by the inside left.

At half-time neither side had scored, and the game continued to be keenly contested.

On resuming Reigate attacked vigorously, but failed to score. Orton, Turner, and Butcher were playing a very sound game. Within a few minutes from time being called the Hospital forwards rushed the goal-keeper, together with the ball, through into the net, thus securing our winning goal. Butcher was particularly conspicuous in goal for the brilliant way in which he saved. Team:

H. H. Butcher (goal); L. Orton, C. H. Turner (backs); E. H. Scholefield, T. Bates, N. E. Waterfield (halves); H. N. Marrett, J. A. Willett, C. O'Brien, V. G. Ward, G. H. Orton (forwards).

HOCKEY CLUB.

The following are the officers for the ensuing season:

President.—Dr. H. Morley Fletcher.

Captain.—D. Jeaffreson.

Secretary.—G. V. Bull.

Committee.—D. Jeaffreson, H. F. Parker, C. A. S. Ridout, A. H. Pollock.

A good list of matches has been arranged.

First Match.—*v.* EPPING.

After a good game we were defeated by 3—2.

Second Match.—*v.* STS. PETER AND PAUL'S, at Teddington.

A good and fast game resulted in a draw of 2 goals all. Towards the end of the first half the Saints scored. Soon after the interval Beckett scored for us, and shortly afterwards Ridout placed us ahead. Even play followed, and just before time the Saints rather luckily equalised. The forwards brought off some good combined runs, and all the backs played well.

Bart.'s Team.—H. F. Parker, D. Jeaffreson, T. H. Gandy (backs); M. O. Boyd, A. H. Pollock, J. A. Nixon (half-backs); A. B. Edwards, A. Hallowes, G. V. Bull, H. Beckett, C. S. Ridout (forwards).

v. HITCHIN. At Hitchin, October 29th.

A pleasant game, despite the rain, resulted in a defeat by 6—3. The Hospital scored first through Beckett, but before half-time Hitchin had a lead of 2 goals. Early in the second half good passing among the forwards resulted in Hallowes and Wilmot scoring, thus making the scores equal. Then Hitchin put on 3 goals; and though the Hospital played up well, and were near scoring on several occasions, they could not get through. The game was more even than the score would seem to indicate. The forwards all played well, but the halves might with advantage keep closer up. Of the back division, Boyd and Jeaffreson were the best, while for Hitchin Lucas and the brothers Foster were best.

Bart.'s Team.—H. F. Parker, D. Jeaffreson, T. H. Gandy (backs); A. H. Pollock, M. O. Boyd, E. H. Hunt (half-backs); A. B. Edwards, A. Hallowes, H. Beckett, G. V. Bull, R. C. Wilmot (forwards).

v. KINGSTON GRAMMAR SCHOOL. November 2nd.

This ended in a severe defeat for the Hospital by 5—0. For us Coalbank and Boyd were in good form.

v. ROYAL OBSERVATORY. November 5th.

A well-contested game ended in defeat by 1—0. Observatory scored in the first half. In the second half the Hospital pressed, but one or two chances were lost owing to off-side.

Bart.'s Team.—D. Jeaffreson, E. P. Glenny, H. F. Parker, J. A. Nixon, H. B. Hill, C. S. Ridout, G. V. Bull, H. Beckett, A. Hallowes, A. B. Edwards.

"A" TEAM *v.* SOUTHGATE 3RD. November 12th.

In this match we found our opponents weaker than we expected, and won easily by 7—0. Goals by Beckett (5), Im Thurn, and Bull.

Bart.'s Team.—L. Gray, D. Jeaffreson, H. B. Hill, A. H. Pollock, M. O. Boyd, J. A. Nixon, A. B. Edwards, G. V. Bull, H. Beckett, R. Im Thurn, R. C. Wilmot.

LAWN TENNIS CLUB.

ST. BART.'S *v.* SOUTHGATE.

Played at Southgate on Saturday, May 14th, and won by Bart.'s by 5 matches to 4, 9 sets to 9, and 90 games to 94:

V. S. A. Bell and J. K. N. Marsh—
- beat C. B. Weir and F. C. Barry, 6—8, 6—4, 9—7.
- beat E. S. Rashleigh and W. C. Hayar, 6—4, 6—3.
- beat C. E. Barker and M. A. Ransome, 7—5 (retired).

J. Stirling-Hamilton and L. Orton—
- beat Weir and Barry, 6—4, 7—5.
- beat Rashleigh and Hayar, 8—6, 6—3.
- lost to Barker and Ransome, 3—6, 6—8.

S. Hey and C. Pennefather—
- lost to Weir and Barry, 3—6, 4—6.
- lost to Rashleigh and Hayar, 2—6, 2—6.
- lost to Barker and Ransome, 2—6, 1—6.

At the annual general meeting of the above Club, held on November 16th, the following officers were elected for the ensuing year:

Captain.—Mr. J. K. N. Marsh.
Senior Hon. Sec.—Mr. J. Stirling-Hamilton.
Junior Hon. Sec.—Mr. C. Pennefather.

The following gentlemen were elected on the Committee:
- 5th Year.—Mr. H. Burrou and Mr. G. V. Bull.
- 4th Year.—Mr. C. H. Barnes.
- 3rd Year.—Mr. H. N. Marret.
- 2nd Year.—Mr. F. E. Murray and Mr. H. Walker.
- 1st Year.—Mr. C. L. Nedwell.

SHOOTING CLUB.

At the annual general meeting, held on Wednesday, October 26th, the following officers were elected for 1899:

President.—H. J. Waring, Esq.
Vice-Presidents.—Howard Marsh, Esq., Henry G. Read, Esq., Dr. Edkins, E. W. Miles, Esq.
Captain.—R. J. Morris.
Secretary.—C. R. V. Brown.
Committee.—W. R. Read, T. H. Gandy, A. C. Brown.

UNITED HOSPITALS RIFLE ASSOCIATION.

The annual general meeting of the United Hospitals Rifle Association will be held in the smoking-room of St. Bartholomew's Hospital on Wednesday, January 25th, 1899, at 5 p.m. It is hoped that members of the metropolitan hospitals interested in shooting will urge their clubs to join the Association in the coming year. The following hospitals have belonged to the Association for varying periods:—St. Thomas's, St. Bartholomew's, Guy's, St. Mary's, Charing Cross, St. George's, the London University College, and King's College; and it is to be hoped that some of these will rejoin the Association, as at the present time there are only four hospitals belonging to it.

At the general meeting each hospital in the Association has two votes for the election of officers for the year; also in matters concerning the alteration of such rules as may be deemed necessary for the welfare of the Association.

The Honorary Secretary will be pleased to receive entries of any hospitals not at present in the Association; also he will be pleased to forward to the Secretary of any Hospital Shooting Club a copy of the revised rules for 1898, and such other information concerning the Association as he may require.

WALTON R. READ,
Hon. Secretary.

St. Bartholomew's Hospital, E.C.

Abernethian Society.

ON Thursday, November 10th, at a meeting of the Society, Mr. Thursfield occupying the chair, Mr. E. W. Roughton read a paper on "The Surgical Treatment of Chronic Otorrhœa." This paper appears *in extenso* in our present issue.

On November 17th (Mr. Thursfield in the chair) a case of primary specific sore on the head was shown; also a case of multiple phleboliths in varicose veins. Mr. Waggett then read a paper on "The Surgery of the Accessory Sinuses of the Nose." In his paper Mr. Waggett said that prominence of the frontal eminences was no criterion of the size of the sinuses, but the forward character of the upper buttress of the nose was better evidence. In speaking of mucous polypi, he said that gravity had much to do with their shape. As to treatment, permanent cleanliness and drainage were necessary. Perhaps it might be needful to extract a tooth; or drainage through the nose, after the method recommended by Luc, might be resorted to.

On November 24th, at a meeting of the Society, Mr. Thursfield being in the chair, Dr. Batten read a paper on "The Muscle Spindle under Normal and Pathological Conditions." At first the method of preparation of the muscle was described. The spindle occurred only in the skeletal muscles, not in the involuntary fibres. It was the sensory nerve termination in the muscle, and had an enormous nerve supply. After section of the anterior nerve-root the muscle atrophied, but the muscle spindle was left absolutely intact. The spindle did not atrophy in such diseases as progressive muscular atrophy and myopathy, but showed changes in tabes dorsalis. There were no spindles in the extrinsic muscles of the eye, but the "organs of Golgi" found there might be their equivalent. Some beautiful microphotographs were thrown upon the screen in illustration of the lecture.

An ordinary meeting of the Society was held on December 1st, Mr. Horder presiding. A case of primary syphilitic sore on the arm was shown, and also one of actinomycosis of the abdominal wall.

Dr. Lewis Jones read a paper on "The Therapeutic Uses of Electricity." At the commencement he made a strong plea for greater interest in the electrical department. The uses of electricity, he stated, could be divided into two great classes:—(1) *Local*, as in crutch paralysis or incontinence of urine. (2) *General.*—Rickets, anæmia, rheumatism, gout, mental failure after various illnesses. The use of electricity for relief of pain was strongly urged. In sciatica little could be done without it. A constant current battery should be used. Its vaso-motor action was very beneficial in bruises, sprains, &c., and in the treatment of chilblains the electrical foot-bath was highly recommended. Many cases of mild infantile paralysis were cured by it, and in severer forms much benefit was experienced. Electricity was used in surgery as a *destructive agent* for nævi, moles, superfluous hairs, &c. Its use for cystoscopic purposes and also as a galvano-cautery was touched on. A very interesting discussion followed. There was a good attendance of members.

The Cambridge Graduates' Club of St. Bartholomew's Hospital.

THE Annual Dinner of the above-mentioned Club was held on Thursday, November 24th, at Frascati's Restaurant, Dr. Howard Tooth (St. John's) being in the Chair.

Between sixty and seventy members, with their guests, sat down to dinner. This was somewhat less than the number of those who had accepted invitations, but doubtless the unfavourable weather prevented many at the last minute from attending.

A most enjoyable evening was spent by all present. Indeed, there was only one matter of regret, and this was that the imminence of the Cambridge examinations had unfortunately kept away most of the musical talent of the Club. It is hoped, however, that this may be remedied in future years by holding the dinner rather earlier in the month.

After dinner, the Queen's health having been duly honoured, the Chairman proposed in happy terms the toast of the evening, viz. "Prosperity to our Club." He reminded us in the course of his speech that the Club was no longer in its earliest growth, it having in reality been founded as long ago as 1877 by the late Mr. Shuter. He dwelt also on the advantages which result to all the members from the existence of the Club, and proved, by the great increase which has taken place of late years in the numbers who attend the dinner, that these advantages are appreciated.

The toast was received with much applause.

Dr. Norman Moore next proposed the health of the Guests, who included amongst others such distinguished and familiar names as Sir Thomas Smith, Mr. Pearce Gould (Surgeon to Middlesex Hospital), the Warden, Dr. Andrewes, Mr. Waring, and last, but very far from least, Mr. Bowlby. In the course of a brilliant speech, full alike of wit, humour, and learning, Dr. Norman Moore touched upon in turn the chief characteristics of our visitors, pointing out particularly that, though they differed much among themselves, yet they all agreed alike in this—that they were no strangers to the Club. The toast was finally coupled with the names of Sir Thomas Smith and Dr. Calvert.

After a short interval, during which Mr. Jordan, accompanied by Dr. Gillespie, kindly played a violin solo,

Sir Thomas Smith rose to respond. He was received at once with that enthusiasm which his presence always evokes at every gathering of Bart.'s men, for, as Dr. Norman Moore truly said, "Kind and genial always, the more he has been honoured of late, the more genial he has become."

He was followed by Dr. Calvert, who, in the course of an appropriate speech, delighted his audience by revealing a deep and extensive knowledge of poetry. Indeed, not content with quoting at length from Shakespeare and Tennyson, he also laid Dante under contribution.

Dr. Lewis Jones then gave the health of the Chairman, to which Dr. Tooth responded.

Lastly, the Chairman proposed the toast of "The Secretaries," Dr. Morley Fletcher and Dr. Horton-Smith, and the latter having briefly replied, the proceedings were brought to a close.

The Month's Calendar.

[Secretaries of Clubs, &c., are requested to co-operate in making this list as complete as possible by forwarding notices of forthcoming events to the Editor.]

1898.
December 16th.—Sir Dyce Duckworth's and Mr. Marsh's duty.
" 17th.—Association F.C. *v.* Crouch End Vampires, at Winchmore Hill.
" 20th.—Dr. Hensley's and Mr. Butlin's duty.
" 21st.—Association F.C. *v.* Tunbridge Wells, at Tunbridge Wells.
" 23rd.—Dr. Lauder Brunton's and Mr. Walsham's duty.
" 27th.—Dr. Church's and Mr. Willett's duty.
" 30th.—Dr. Gee's and Mr. Langton's duty.

1899.
January 3rd.—Sir Dyce Duckworth's and Mr. Marsh's duty.
" 5th.—Christmas Entertainment by St. Bartholomew's A.D.C. Performance of "The Balloon" and "No. 1 round the Corner."
" 6th.—Dr. Hensley's and Mr. Marsh's duty. Second performance by A.D.C.
" 10th.—Dr. Lauder Brunton's and Mr. Walsham's duty.
" 12th.—Abernethian Society address at 8 p.m. Mr. James Berry on "Dressers and Dressing."
" 13th.—Dr. Church's and Mr. Willett's duty.
" 14th.—Association F.C. *v.* Cheshunt, at Winchmore Hill.

Review.

NASAL OBSTRUCTION: the Diagnosis of the Various Conditions causing it, and their Treatment, by W. J. WALSHAM, M.B., C.M.Aber., F.R.C.S.Eng., Surgeon and Lecturer on Surgery, St. Bartholomew's Hospital, &c. (London: Bailliere, Tindall, and Cox, 1898. Demy 8vo, pp. 256. Thirty-four illustrations.)

The author of these pages may well refer to the diagnosis of nasal disease as "a department of practice to which students and general practitioners have not hitherto given much attention." The interior of the nose and the route to its accessory sinuses is to many students, and to not a few practitioners, a *terra incognita*—a region darker than darkest Africa.

The frequency of nasal obstruction, the grave consequences to which it may give rise when disregarded, the comparative ease with which an exact diagnosis can be arrived at by a systematic examination, and lastly, the evils that can be prevented and the relief afforded by appropriate treatment, suffice to render the subject deserving of further attention, and the work done by Mr. Walsham most welcome.

The first half of the book deals with the diagnosis of the condition. The method adopted is that of "working from the known to the unknown," "from the known condition of the parts to the unknown disease of which they are signs and symptoms." This of necessity involves some repetition, but the method is essentially clinical and thoroughly practical. One of the practical aids to exact diagnosis upon which we are glad to see stress laid is the use of the nasal probe. To the pitfalls and fallacies in diagnosis attention is drawn:

> Further, should some obstructive lesion connected with the turbinals be discovered, it must not be concluded that this is necessarily the sole cause of the obstruction; thus, an erection of the turbinals may depend upon adenoid vegetation in the vault of the pharynx, these growths being the real cause of the trouble; or, again, an enlargement of the middle turbinal or a polypus on that body may be associated with chronic purulent catarrh of one of the accessory sinuses. The naso-pharynx should therefore always be examined, and in some cases the accessory sinuses also.

The second half of the book is given up to the treatment of conditions causing obstruction. The operations for the

removal of nasal obstructions are fully described. The fascinating but questionable procedure of complete turbinectomy is justly criticised. The sections dealing with the correction of nasal deformities, coming from one who has had exceptional experience in this branch of artistic surgery, will command considerable attention.

It would seem ungracious and ungenerous to find fault. In a future edition plates illustrating the anatomy and pathology of the parts dealt with might be advantageously added, and if necessary some of the instruments figured might be omitted without detracting from the usefulness of the work. The strengths of the solutions of cocaine given for purposes of diagnosis are excessive, and the strength of the solution of eucaine mentioned for operative purposes is perhaps insufficient.

The satisfactory character of the whole book is due to the author being possessed not only of considerable experience in the subject, but also of many years' experience as a clinical teacher. The book is a clear presentment of the clinical facts which must be borne in mind by one studying the subject. Readers, therefore, who desire to be posted up in the general outlines of nasal obstruction, and, for that matter, of nasal surgery, cannot do better than read this volume.

Appointments.

BARFORD, P. C., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed Surgeon to the P. & O. ss. Malta.

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CORY, C. G., M.R.C.S., L.R.C.P., appointed Medical Officer and Public Vaccinator to the Seventh District of the Newmarket Union.

* * *

RAWLINGS, J. D., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed Medical Officer and Public Vaccinator for the Northern District of the Dorking Union.

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EVANS, E. LAMING, M.A., M.B.(Cantab.), appointed House Surgeon to the Royal Orthopædic Hospital.

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EVANS, E. W. SPENCER, M.R.C.S., L.R.C.P., appointed Surgeon to the Orient ss. Oroya.

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FURNIVALL, P., F.R.C.S., appointed Assistant Surgeon to St. Mark's Hospital.

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GRAHAM, J. H. P., M.R.C.S., L.R.C.P., appointed Surgeou-Lieutenant to 4th V.B. the King's (Liverpool Regiment).

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HOGARTH, R. G., F.R.C.S.Eng., appointed Surgeon to the Samaritan Hospital for Women, Nottingham.

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MCLEAN, W. W. L., M.R.C.S., L.R.C.P., reappointed Temporary Plague Officer by the Indian Government.

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WOODFORDE, R. E. H., M.R.C.S., L.R.C.P., appointed House Surgeon to the Huntingdon County Hospital.

Examinations.

UNIVERSITY OF CAMBRIDGE.—*Diploma of Public Health.*—A. G. Penny.

UNIVERSITY OF LONDON.—*M.B. Honours Examination: Medicine.*—Gold Medal, T. J. Horder. *Obstetric Medicine.*—Scholarship and Gold Medal, J. P. Maxwell; Gold Medal, T. J. Horder. *Forensic Medicine.*—Gold Medal, T. J. Horder.

M.B. Examination: First Division.—T. J. Horder. *Second Division.*—F. Brickwell, G. D. Freer, J. P. Maxwell, P. W. Rowland, H. A. Schölberg, G. P. Tayler.

ROYAL COLLEGE OF SURGEONS.—*Final Examination for Diploma of Fellow.*—W. Stuart Low, A. W. Ormond, A. J. Rodocanachi, G. H. Sowry, A. W. Sikes, Claude Worth. *First Examination for Diploma of Fellow.*—A. T. Compton, E. Laming Evans, E. H. Hunt, N. Maclaren, S. H. Modi, F. E. Murray, H. Walker, R. H. K. Whitaker, C. E. West.

SOCIETY OF APOTHECARIES.—*Final Examination: Midwifery.*—R. F. Ellery.

Changes of Address.

CORY, C. G., M.R.C.S., L.R.C.P., from Cambridge to Soham, Cambs.

GRAHAM, J. H. P., M.R.C.S., L.R.C.P., from New Brighton to West Derby, Liverpool.

HORNE, W. JOBSON, to 27, New Cavendish Street, Harley Street, W.

Birth.

HOOKER.—November 29th, at Cirencester, the wife of Charles P. Hooker, L.R.C.P., F.R.C.S.Ed., of a son.

Marriages.

BUTTAR—SYRETT.—On the 10th December, at St. Andrew's, Westminster, by the Rev. E. B. Woodman, Charles Buttar, M.D., of 2, Prince's Square, W., to Georgie Isabel, daughter of Ernest Syrett, of River House, Walton-on-Thames.

CHAPLIN—SETON-SMITH.—On November 17th. at St. Mary's, North-end, Arnold Chaplin, M.D., of Finsbury Square, to Joan, widow of the late Bruce Seton-Smith, of Richmond.

LOWE—JAMES.—On the 17th inst., at the Parish Church, Louth, by the Rev. Canon Wilde, M.A., Rector, assisted by the Rev. D. H. Ellis, B.D., LL.D., Mus. Bac., Vicar of St. Botolph's, Lincoln, Godfrey John Ralph Lowe, M.R.C.S., L.R.C.P., L.S.A., third son of Dr. G. M. Lowe, Lincoln, to Alice Maud Mary, youngest daughter of the late Thomas James, F.R.C.S., and Mrs. James Westgate, Louth.

Deaths.

CLARKE.—On November 24th, at 3, Chandos Street. Cavendish Square, Doris Litton, the infant daughter of Ernest and Kate Litton Clarke.

SMITH.—On November 12th, at Margate, Walter Woodbine Smith, Surg.-Captain, R.A.M.C., son of the late Deputy Surg.-General Charles E. Smith, of peritonitis after typhoid fever.

ACKNOWLEDGMENTS.—*Guy's Hospital Gazette, Nursing Record, St. George's Hospital Gazette, St. Thomas's Hospital Gazette, St. Mary's Hospital Gazette, London Hospital Gazette, The Stethoscope, M. R. I., Guyoscope, Medical and Surgical Review of Reviews, The Hospital.*